STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003312	A. BUILDING: _____ B. WING _____	C 11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HEART HOSPITAL THE	8075 N SHADELAND AVE INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of a State hospital complaint. Complaint Number: IN 00133932 Unsubstantiated; lack of sufficient evidence. Survey Date: 11-01-13 Facility Number: 003312 Surveyor: Brian Montgomery, RN Public Health Nurse Surveyor The Indiana Heart Hospital is in compliance with 410 IAC 15-1.5-6 Nursing service, 410 IAC 15-1.5-10 Utilization review and discharge planning services, and 410 IAC 15-1.6-2 Emergency services, Indiana Hospital Licensure Rules. QA: claughlin 11/12/13	S 000		